

2017

Nebraska Behavioral Health All-Hazards Disaster Response & Recovery Plan

NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

DIVISION OF BEHAVIORAL HEALTH

PREPARED BY

UNIVERSITY OF
Nebraska
PUBLIC POLICY CENTER



NEBRASKA

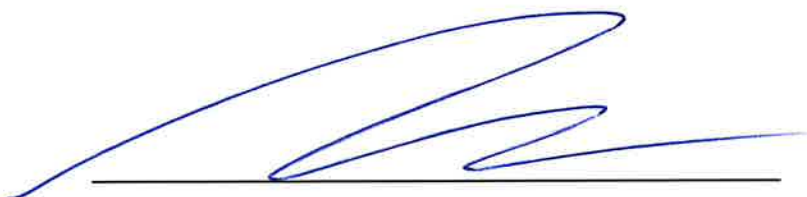
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Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan

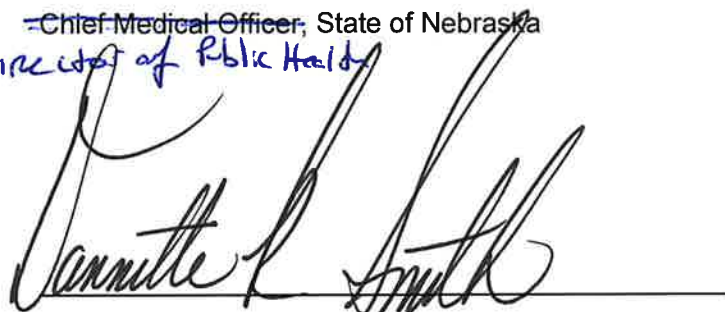
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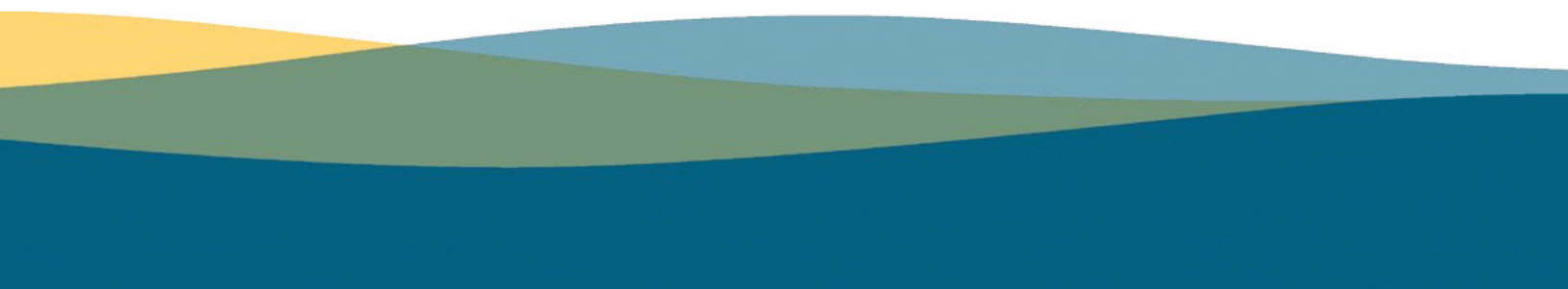
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I. Executive Summary

The Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan is a guide for personnel responsible for state behavioral health disaster coordination. The plan narrative includes:

- General assumptions upon which the plan is built
- Concept of operations in a disaster
- Information pertinent to the identification and deployment of trained disaster behavioral health personnel

The appendices contain:

- Information that may assist in the coordination and organization of a disaster behavioral health response
- Relevant statutory information
- General disaster mental health and substance abuse information
- Guidelines for preparation of Federal Crisis Counseling Program grants
- Forms to help document response activities

Nebraska depends on volunteers to carry out behavioral health interventions related to disaster response and recovery. Behavioral health preparedness activities are directed by the Nebraska Department of Health and Human Services, Division of Behavioral Health and carried out by the six Behavioral Health Authorities located across the state.

Disaster behavioral health response activities fall under public health incident command structures locally and at the state level. Local disaster behavioral health resources in Nebraska include locally trained and managed volunteers; mental health functions for the American Red Cross and other Voluntary Organizations Active in Disaster; and local Medical Reserve Corps.

State resources may be requested if an event exceeds the capabilities of a local area. These resources include the State Critical Incident Stress Management Team (CISM), State Behavioral Health Emergency Response Team, State Risk Communication Cadre, and consultation services from subject matter experts.

Coordination with other response entities is an important part of Nebraska's plan to deliver disaster behavioral health interventions. Partners in planning, response and recovery include spiritual care providers, emergency management, public health and healthcare, and first responders.

Deployment of disaster behavioral health resources begins with a request from emergency management. Local and state behavioral health teams are organized using incident command concepts and supervised in the field by qualified personnel familiar with disaster behavioral health service delivery and the local area.

II. Purpose of this Plan

The purpose of this plan is to provide a framework for organizing the Nebraska behavioral health response to disasters. Behavioral health in Nebraska includes mental health, substance abuse, and addictive behaviors.¹ Behavioral Health disaster response addresses psychological, emotional, behavioral and social issues which may arise from a disaster event. Disaster behavioral health services can help mitigate the severity of adverse psychological effects of the disaster and help restore social and psychological functioning for individuals, families, and communities.

This plan is meant to be a dynamic document that can be modified to incorporate changing technologies and emerging best practices in behavioral health. The plan provides guidelines for use by the Nebraska Department of Health and Human Services, Division of Behavioral Health in its role as state coordinator of behavioral health care related to disaster. It also serves as a template for local behavioral health disaster planning.

III. Assumptions & Situation

Guiding Principles

These guiding principles provide the basis for organizing the behavioral health response to disaster in Nebraska.

1. All-hazards disaster response is a local responsibility first.

The first response to a disaster always occurs locally. The capacity to respond to the psychological effects of disaster must also be organized and implemented at the local level first. Local planners understand the cultural, social, and psychological needs of people in their area. The Nebraska Plan builds on the strengths of our communities.

2. Disaster behavioral health is usually (but not always) part of a larger, multi-layer, multi-disciplinary disaster response.

Disaster behavioral health responders typically work in concert with health care providers, public health, emergency management, first responders, and members of Nebraska Voluntary Organizations Active in Disasters (NEVOAD).

3. The public behavioral health disaster response in Nebraska is organized and coordinated via the six Regional Behavioral Health Authorities in Nebraska.

The State recognizes that local behavioral health disaster resources are limited and may be overwhelmed if the effects of the disaster are severe or widespread. Regional coordination of human resources facilitates mutual aid and pooling of resources, and provides a single point of contact if additional resources are needed.

¹ Nebraska Behavioral Health Services Act, Neb. Rev. Stat. §§ 71-801 to 71-830

4. State level involvement in the behavioral health response to disaster builds upon the structure and organization of the local and regional response.

Human resources mobilized by the State will support and build upon the structured response identified by the local and regional entities responding first to the disaster. The State will augment, not replace, community structures already in place to deliver disaster behavioral health services.

5. Nebraska Voluntary Organizations Active in Disasters² (NEVOAD) members are valuable partners in meeting the psychological, social, and spiritual needs of people in disaster.

6. Natural support systems during response to a disaster may include disaster spiritual care. Spiritual care contributes to promotion of resilience before and after a disaster.

7. Disaster behavioral health interventions may be systemic³ and long-term, with the early goal of stabilizing the psychosocial reactions of survivors, and the later goal of restoring or rebuilding the social fabric of a community.

8. The tendency of people to seek assistance from natural support systems creates a need for Disaster Behavioral Health Professionals to serve as a resource in a consultative role for natural support systems.

Service provision for disaster behavioral health includes working with families and institutions (e.g., churches, schools, neighborhood groups). The consultative role includes being available for questions and acting to equip individuals and groups with the information and tools they need to provide psychological first aid to the people who turn to them for assistance.

9. Individual disaster behavioral health services must be appropriately delivered, and adjusted to be gender and culturally sensitive, linguistically and developmentally appropriate, and suitable for the type, scope, and phase of the disaster.

10. Interventions during disaster response and recovery should be based on accepted professional standards and practices, to the extent possible
Interventions directed at treatment of trauma or disaster-related problems should be evidence-informed⁴ when possible.

² Nebraska VOAD is an umbrella organization of existing voluntary agencies. Each member organization maintains its own identity and independence, yet works closely with other agencies to improve service and eliminate unnecessary duplication of efforts in times of disaster.

³ Systemic interventions are used with communities, families, & institutions. An example of a systemic intervention is a mental health clinician who equips teachers to screen children in their classrooms for disaster stress while the teacher provides education about coping with the disaster stress. More children are touched by this systemic intervention than could be reached by placing an individual clinician in a school to personally screen all children.

⁴ There is a growing body of evidence about clinical practices that seem to alleviate disaster-related problems. It is important for disaster clinicians to remain up to date on the latest research related to their practice.

Relevant Geography

Nebraska is 76,872 square miles, averaging 23.8 persons⁵ per square mile. The majority of people in Nebraska live in the eastern third of the state or along the central corridor (Interstate 80/Platte River). The 2016 population estimate for Nebraska is 1,907,116 persons. Nebraska has a large agricultural sector with 45,200,000 acres of farmland with a variety of crops, and livestock.⁶

Relevant Demography

General Demographic Considerations

- Rural residents live in areas with few or no behavioral health professionals
- 11.1% of Nebraskan's speak a language other than English at home with Spanish as the predominant language other than English
- There are four federally recognized tribes headquartered in Nebraska each of which have claims to sovereignty and a government-to-government relationship with the State and Federal governments.
(Omaha Tribe; Ponca Tribe; Santee Sioux Nation; Winnebago Tribe)



Populations with Unique/Functional Needs

- Children under age 18 account for 24.8% of Nebraskans
- Adults age 65 or older make up 14.7% of the population
- 12.6% of Nebraskans have incomes below the poverty level
 - 7.3% of Nebraskans under age 65 have a disability⁷ (e.g., developmental, physical, psychiatric disabilities)
- People with a history of substance abuse
 - Substance use may increase after a disaster for those with pre-existing substance use/abuse issues.⁸
 - Depending on the disaster, access to treatment may be hindered, particularly for those in opioid treatment programs. (People from across the state are served by Nebraska's Opioid Treatment Programs (OTP) that are primarily located in the eastern third of the state.)
- Approximately 75% of adults in Nebraska identify as Christian, 5% as other

⁵ Source U.S. Census Bureau: State and County QuickFacts. Last Revised: July 1, 2016

⁶ USDA, National Agricultural Statistics Service. Data as of March 8, 2017

⁷ U. S. Census Bureau, 2015 American Community Survey.

⁸ North, C. (2004, July). *Data-based foundations for disaster mental health intervention and policy*. Presented at the Second Annual Nebraska Disaster Behavioral Health Conference, Omaha, NE.

faiths and 20% as unaffiliated⁹

- New Nebraskans, often refugees, may have come from areas of the world where they experienced disaster, war, or famine
- Other populations that may have unique needs include people who are homeless, in institutions, long-term care facilities, college dorms, and other multi-person dwellings

Probable Disaster Situations in Nebraska

The Nebraska Emergency Management Agency identified Flooding, Tornadoes and Wildfires as the top three hazards in the state. Other potential hazards include:

Natural Hazards

- **Weather related disaster** such as drought, ice, wind, or snow storms
- **Earthquake risk** is difficult to estimate in Nebraska. The New Madrid fault runs through part of Nebraska. More than 50 earthquakes, almost all less than Richter 4.0, have occurred in Nebraska since 1867. Some of the earthquakes were between Richter 4.0 and 6.0, a magnitude large enough to overturn unstable objects and break dishes and windows.¹⁰

Technological Hazards

- **Biological or Chemical** disaster risk for Nebraska is largely unknown, though the agricultural nature of the State creates unique vulnerabilities in this area. Risks to crops, food production, or the animal industry through intentional or unintentional contamination or disease could result in a number of economic and psychological consequences. Risk of chemical disaster is highest for chemicals such as anhydrous ammonia and other agricultural chemicals
- **Nuclear disaster** risk is related to the transportation and storage of nuclear waste, and the presence of one nuclear power plant in Nebraska (Cooper in Brownville)
- **Transportation system accidents** (railroad, busing, trucking, air travel)

Security Hazards

- This includes terrorist events or disasters linked to illegal activity resulting in community trauma or disruption. The psychological consequences related to these events tend to be more pronounced than for disasters stemming from natural or technological hazards

Public Health Threats

- Disease events such as flu, Ebola or similar highly contagious disease are possible in Nebraska. Population based behavioral health consequences vary depending on level of exposure and degree of impact for the disease.

⁹ <http://pewforum.org/religious-landscape-study/state/nebraska>

¹⁰ USGS Earthquake Hazards Program. Retrieved March 15, 2017, from: <https://earthquake.usgs.gov/earthquakes/byregion/nebraska.php>

IV. Concept of Operations

Local Response Structures

Local Emergency Management structures are organized by county in Nebraska. Under state law, all local jurisdictions are responsible for initial response to a disaster.¹¹ Each county has a Local Emergency Operations Plan (LEOP). The local plan may contain information about how that county intends to meet the psychological and social needs of people in that area after a disaster.

Local Public Health Departments are located across the state. Some are organized by county and others by multi-county districts. Public health departments are responsible for coordinating with the behavioral health disaster response in their local area.

Local behavioral health structures are organized under Regional Behavioral Health Authorities. These multi-county Regions serve as the conduit for public behavioral health funding and as the coordinating body for public behavioral health services. The Division of Behavioral Health within the Nebraska Department of Health and Human Services is responsible for ensuring there is statewide access to behavioral health services through these regional structures.¹² Nebraska administrative code currently states that the Regional Governing Board must have the capacity to respond to the psychosocial needs of disaster victims within the Region's assigned geographic area.¹³ The Regional Behavioral Health Authorities coordinate with local Public Health Departments to mobilize and oversee the behavioral health disaster response.

The challenge associated with coordinating service provision among local structures is that the geographic areas used to organize them are all different. Public Health districts, CISM troop areas, Regional Behavioral Health Authorities, and Local Emergency Management coverage areas differ.

Coordination of the Behavioral Health Disaster Response

The Local Emergency Operations Plan (LEOP), the Local Public Health Emergency Response Plan, and the Regional Behavioral Health Disaster Response and Recovery Plan should designate someone from the area as a disaster behavioral health coordinator. Local providers or agencies are in the best position to understand what may work best with the human resources available. However, emergencies can occur that require more assistance from behavioral health disaster resources than are available in the local area. For this reason, the Behavioral Health Regions serve as the primary local link to regional resources.

¹¹ Nebraska Emergency Management Act, §§ 81-829.46 to 81-829.50

¹² The Nebraska Behavioral Health Services Act, passed by the Nebraska Unicameral July 1, 2004, designates the geographic coverage of each Region and creates a Division of Behavioral Health within the Department of Health and Human Services, §§ 71-805 to 71-807

¹³ Nebraska Administrative Code Title 204 Chapter 3-008

Regional Behavioral Health Authorities designate a person(s) to serve as Regional Disaster Behavioral Health Coordinators. The Regional Administrator will ensure the name(s) and contact information for the disaster coordinator(s) for the Region is communicated to the Division of Behavioral Health, Disaster Behavioral Health Coordinator annually on July 1 and will provide up to date information if anything changes (e.g., names, phone numbers, emails) over the course of the year. These coordinators serve as a link between emergency management, public health, and other agencies and organizations within local communities, and the State Division of Behavioral Health. The State will look to the Regions to provide local behavioral health information needed to prepare a FEMA Crisis Counseling Program or other similar grant application if a disaster occurs that makes the area eligible to receive it.¹⁴

State level coordination of resources during a disaster **occurs only when local and regional resources are inadequate or overwhelmed or when the Governor's Authorized Representative (GAR) activates a state disaster behavioral health team for a specific mission.**

The Division of Behavioral Health is responsible for maintaining capacity and readiness on the state level to assist communities in meeting their behavioral health needs following a disaster. The Director of the Division of Behavioral Health will designate staff, volunteers, or personnel from other State entities with requisite experience and knowledge to serve as State Disaster Behavioral Health Coordinators. These coordinators serve as liaisons from the State Division of Behavioral Health to Regional Behavioral Health Authorities, to other Nebraska State agencies, and to other states with disaster behavioral health needs. Links to the Nebraska Emergency Management Agency (NEMA) are particularly important, as NEMA is a link to all other emergency management activities in the state. The Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan serves as the disaster operational plan for NE DHHS Division of Behavioral Health.

SUMMARY

- Local Plans recognize human resources available in the area to meet psychological and social needs of community members following disaster
- Regional Behavioral Health Authorities designate Regional Disaster Behavioral Health Coordinators
- The Nebraska Department of Health and Human Services, Division of Behavioral Health designates State Disaster Behavioral Health Coordinators

¹⁴ FEMA Crisis Counseling Grant Application information is available in the Appendix.

Coordination with Other Disaster Response Functions/Agencies

The Nebraska Emergency Management Agency (NEMA) maintains the State Emergency Operations Plan (SEOP). The SEOP places DHHS in charge of organizing and activating the behavioral health disaster response for the state, excluding the normal deployment of NEVOAD agencies. The Nebraska Department of Health and Human Services **ESF #8 Coordinator** is assigned to the NEMA Emergency Operations Center (EOC) and serves as the DHHS link with state disaster response activities. **The link with NEMA is important because it ties in the state behavioral health response with Nebraska Voluntary Organizations Active in Disasters (NEVOAD) and government response structures.**

The Division of Behavioral Health makes one of the State Disaster Behavioral Health Coordinators available to participate in regular **DHHS disaster activities** to ensure readiness and coordination with other DHHS functions.

Local emergency management and local public health departments coordinate with Regional Behavioral Health Authorities to identify local behavioral health providers and response agencies, and to identify someone who can serve as the primary local behavioral health disaster response contact.

Summary

- State coordination occurs formally through the Nebraska ESF #8 Coordinator
- The state behavioral health response ties in with VOAD through the ESF #8 Coordinator
- Local coordination facilitated through Regional Behavioral Health Authorities

Overview of Actions Before, During, & After a Disaster

Before a Disaster Occurs - Preparedness

Every disaster is different, but there are common things that can be done to prepare and be ready to respond when an event occurs.

Local Activities

- Review Local Emergency Operations Plans to ensure existing plans address behavioral health needs of people affected by a disaster.
- Participate in joint exercises to test emergency plans. Encourage inclusion of behavioral health responders as exercise support and participants.

- Familiarize behavioral health providers and volunteers with the Incident Command System,¹⁵ an approach that details a strategy to define how behavioral health, public health, emergency management, hospitals, and other responders prepare, coordinate, and respond to an event.
- Identify faith based leaders who are trained in Disaster Spiritual Care.
- Record key response contacts for behavioral health.

Regional Activities

- Foster relationships among Emergency Management, Public Health Departments, and those responsible for responding to behavioral health disaster needs in each county included in the Behavioral Health Region.
- Develop and maintain Regional Behavioral Health Authority disaster response and recovery plans.
- Identify Regional Behavioral Health Authority personnel who may serve as Regional Disaster Behavioral Health Coordinators.¹⁶
- Forward contact information for Regional Authority Disaster Behavioral Health Coordinators to local Emergency Managers, the local Public Health Department(s), and the State Division of Behavioral Health.
- Make psychological first aid training available to all involved in disaster response, specifically targeting community responder volunteers who may augment the behavioral health response to disaster.
- Maintain, by the Regional Authority or in coordination with a partner agency (such as Medical Reserve Corps or Public Health), a list of local volunteer behavioral health responders.
- Manage forms and materials that may be needed as part of a disaster behavioral health response.
- Work with mental health, substance abuse and opioid treatment programs to ensure plans are in place for continuity of service in the event of a disruption.

State Activities

- The DHHS Division of Behavioral Health identifies State Disaster Behavioral Health Coordinators.^{17,18}
- The Division of Behavioral Health creates, fosters, and/or makes available information about training opportunities related to the psychological and social aspects of disaster response and recovery.
- The Division of Behavioral Health, together with Public Information Officers for

¹⁵ See Appendix for information on the Incident Command System.

¹⁶ A key contact may be identified by the Region to do preparedness activities. It is recommended that at least 5 people be identified to serve in this role should disaster occur to insure that the role is covered.

¹⁷ Neb. Rev. Stat. 71-806 "The division shall act as the chief behavioral health authority for the State of Nebraska"

¹⁸ Similar to the recommendation for Regions, the State should identify a key contact(s) to carry out preparedness activities. It is recommended that at least 3-5 people be identified and familiarized with the role of the State Disaster Behavioral Health Coordinator to insure the role is covered in the event of a disaster.

the State of Nebraska, identifies a pool of licensed/certified behavioral health professionals with expertise in risk communication to serve as consultants for risk communication efforts.

- The Division of Behavioral Health maintains a list of pre-identified and trained Nebraska Behavioral Health Emergency Response Team (BHERT) members to provide needs assessment, consultation, service provision and training as required.
- State Disaster Behavioral Health Coordinators, BHERT members, and Risk Communication Consultants convene regularly to:
 - Review the Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan
 - Participate in State-level disaster exercises and/or training
 - Make key contacts with State-level response agents
 - Review the application process for the FEMA Crisis Counseling Grant Program or similar Disaster Recovery Grants.
 - Review current contact information and activation mechanisms for the Nebraska ESAR-VHP and MRC Program, American Red Cross, Nebraska Critical Incident Stress Management (CISM) teams, and NEVOAD members that provide statewide disaster assistance related to meeting the psychological and or social needs of those touched by disaster
 - Maintain key contacts with Regional Disaster Behavioral Health Coordinators

After a Disaster Occurs - Response

No flowchart or list of duties can accurately depict the exact sequence of events for every disaster response, however there are predictable formal lines of authority that must be observed when requesting or deploying disaster response structures. [Figure 1](#) depicts these formal lines. Response agencies and personnel should use the Incident Command System (ICS) structure.

The numbered items below serve as a general guide for Nebraska's behavioral health disaster response.

1. The appendices contain guidelines and checklists to serve as tools for Regional and State Disaster Behavioral Health Coordinators responding to a disaster.
2. Local emergency management (often through public health) must activate the behavioral health response. Regions are encouraged to contact public health and emergency management to discuss the role of a behavioral health response in the current event.
3. Regions should encourage local emergency management to engage them early in the response to conduct an initial assessment of the behavioral health needs of individuals and the community affected by the disaster.
4. Regional Behavioral Health Authorities oversee the behavioral health response in their areas, sometimes jointly with other agencies, and should be involved in behavioral health deployment and coordination decisions.

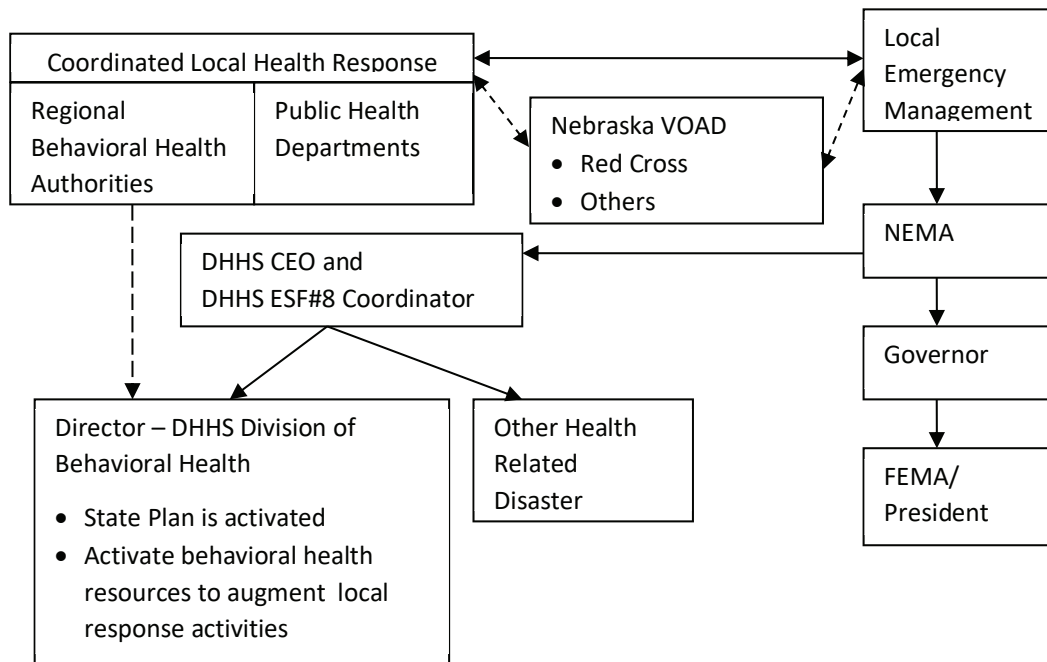


Figure 1. Overview of response coordination among agencies.

5. Regional Behavioral Health Authorities work with local resources to track the scope of the response from its onset including:
 - The number and type of behavioral health resources deployed (Organizations & Individuals; Volunteers & Paid Responders)
 - The number and type of individual contacts made by behavioral health responders
 - Costs incurred as a result of the deployment
6. Regional Disaster Behavioral Health Coordinators, in consultation with local resources, notify local emergency management and local public health departments if the disaster type, size, or scope overwhelms the ability of local and Regional Authority resources to adequately respond to the psychological and social needs of those affected by the disaster. (Regional Disaster Coordinators should also notify the Division of Behavioral Health of this decision so locating additional resources can begin. The Division of Behavioral health will receive the official request for additional resources through the Emergency Management system.)
7. Local Emergency Management notifies the Nebraska Emergency Management Agency that area resources in disaster behavioral health are overwhelmed and that additional assistance from the State is required.
8. The Nebraska Emergency Management Agency follows the protocol laid out in the State Emergency Operations Plan (SEOP) and notifies the CEO of the Department of Health and Human Services that State involvement is needed to

support the behavioral health response in the affected area.

9. The Department of Health and Human Services CEO designates the Division of Behavioral Health to assign the State Disaster Behavioral Health Coordinator(s) to work with Regional Disaster Coordinators, the American Red Cross, other active VOAD agencies, and the Nebraska CISM team to identify and deploy appropriate resources to the affected area.
10. Once the disaster progresses through the response phase toward recovery, the Division of Behavioral Health works with the Regional Behavioral Health Authorities to identify recovery needs related to behavioral health in the affected area.

Likely Sites of Intervention

There are a variety of sites where behavioral health disaster responders may be needed. Behavioral health is often not needed at the site of the incident. Although it is a common reaction to want to rush to these sites, the assistance that behavioral health responders provide will most likely be needed at other sites where people gather.

Local and Regional Behavioral Health Authority Disaster Coordinators must be prepared to ensure behavioral health disaster response workers are deployed to the following sites as needed, in coordination with other organizations with behavioral health responders (e.g., American Red Cross) and spiritual care providers:

- Sites where survivors and families of victims gather
 - Shelters, meal sites, disaster application centers, Red Cross service centers, hospitals, schools, police stations, survivors' homes, morgues, farms or ranches, police barriers/perimeters, etc.
- Mass care sites
- Mass clinics for immunizations and/or prophylactic medications
- Sites where first responders and other response workers gather (*coordinate this work with the Nebraska CISM Program*)
- Sites conducive to community education and outreach (Community centers, shopping malls, schools, religious centers, business associations)
- Organizations who request behavioral health response services (Businesses, affected neighborhoods, farms or ranches)

Behavioral health disaster related concerns include the needs of people already served by the behavioral health system. **A plan for continuity of services is primarily the responsibility of the service provider or facility.** In some situations, however, disaster service provision may need to be augmented with disaster behavioral health services. Service providers should recognize when their clients are affected by a disaster and request additional resources when needed from the Regional Behavioral Health Authority covering their area.

State Behavioral Health Coordinators should be prepared to identify state behavioral health resources or work with Regions to identify behavioral health personnel to:

- Provide appropriate support to State-sponsored hotlines (i.e., support to staff, training, crafting risk messages)
- Respond to behavioral health needs related to disaster involving State-operated facilities in affected areas
- Work with Regional Behavioral Health Authorities
- Augment Regional Behavioral Health Authority resources when needed
- Respond to missions issued by the Nebraska Emergency Management Agency

After a Disaster Occurs – Recovery

Recovery is a process that occurs over time for individuals and communities. Psychological and social needs in recovery are dependent upon a number of factors, including the pre-existing state of individuals and communities, the nature, scope, and severity of the disaster, and the type of assistance that is made available through formal response mechanisms. Generally, recovery is a local responsibility but there may be opportunities for assistance from State and Federal resources to meet this responsibility.

1. First Responders and other emergency service personnel may be aided through pastoral care and the Nebraska CISM program.¹⁹
2. The Division of Behavioral Health monitors activities and needs of affected areas so it is in a position to advocate for resources and funding if they become available.
3. Declarations of disaster by the Governor may increase the likelihood of resources becoming available to the affected area to aid in recovery.
4. Declarations of disaster by the President may create opportunities for reimbursement for response activities and the opportunity to apply for the FEMA Crisis Counseling Program (CCP). DHHS Division of Behavioral Health is responsible for deciding whether to apply for a FEMA CCP, and will assemble the application with the assistance of the Regional Behavioral Health Authority responsible for serving the affected locations. (Detailed information about applying for FEMA CCP is available in the Appendix).
5. Long-term recovery may also involve formation of groups to address unmet needs in a community resulting from the disaster which could involve behavioral health.
6. Regional Behavioral Health Authority Disaster Coordinators are responsible for reporting recovery needs and progress to the State Division of Behavioral Health through the State Disaster Behavioral Health Coordinator even if they are not involved in administering a FEMA CCP.
7. Administrative review of a completed response should include the following:

¹⁹ Per NAC Title 176 Chapter 1, and the Nebraska Critical Incident Stress Management Act §§ 71-7102 and 71-7113, emergency service personnel includes: law enforcement personnel, firefighters, emergency medical services personnel, dispatchers, rescue personnel, hospital personnel, corrections personnel, and emergency management personnel.

- Conduct a review of activities
 - Which parts of the plan worked and didn't work?
 - What lessons were learned from the experience?
 - What could be done differently or better next time?
- Assign a representative to draft an after-action review document
 - What actions were taken during the incident and the results of these efforts?
 - What resource needs were identified as a result of the incident?
 - What will be done to improve the response in the future?
 - What was learned about responding to such an incident?
- Identify gaps and propose remedies for the local or statewide public behavioral health response – revise procedures and plans accordingly

V. Legal Authorities

Division of Behavioral Health, Nebraska Department of Health and Human Services

The Nebraska State Emergency Operations Plan (SEOP) assigns the Nebraska Department of Health and Human Services with maintaining plans and procedures to respond to the psychosocial needs of disaster victims within the state, and for interstate aid (SEOP ESF-6, 8, and 11).

All state agencies and political subdivisions of the state are required to cooperate and extend their services and facilities for the purposes of disaster response upon request.²⁰ The Division of Behavioral Health is responsible for cooperating with other state agencies to identify behavioral health personnel who can be shared or activated to respond to state disaster behavioral health needs, and to establish contacts/protocol for activating such a response.

Regional Behavioral Health Authority

The state's six Regional Behavioral Health Authorities are required to have a written plan to respond to psychosocial needs of disaster survivors in their coverage area.²¹

Health Care Facilities and Services Licensure

Facility licensure requirements address disaster preparedness in terms of meeting physical needs and continuation of services. This also applies to certification of aging services and mental health programs.²²

²⁰ Nebraska Emergency Management Act § 81-829.60

²¹ NAC Title 206 Chapter 4

²² NAC Title 15 NAC 1; and Title 205 Chapter 5

Nebraska Critical Incident Stress Management Program

The Nebraska Critical Incident Stress Management (CISM) Program is authorized by statute to provide system support services when requested by emergency responders, law enforcement, dispatchers, correctional staff, hospital, and emergency management personnel throughout Nebraska. The CISM Program provides services to public safety personnel to help prevent and to ameliorate stress-related symptoms. It is not the function of the Program to replace on-going professional counseling or psychotherapy, but to provide education, prevention and crisis intervention.²³ CISM is the only statutorily funded program in Nebraska for responding to psychosocial needs in a disaster.

Mobilization of Responders

Locally, the emergency management director or coordinator is responsible for developing mutual aid arrangements for reciprocal aid and assistance in the event of a disaster or emergency.²⁴ This includes developing mutual aid arrangements with agencies and organizations in other states. Additionally, licensure or certification in another state will be recognized as evidence of qualification for utilizing the licensed skills for disaster response in the State of Nebraska.²⁵

Under the Nebraska Emergency Management Act, a roster of persons with training and skills for disaster response can be established as an emergency response team.²⁶ Only the people who appear on such a roster will be considered members of a disaster response team and therefore covered by the emergency management act.²⁷ A general roster of individuals who can potentially volunteer is not the same as the team roster submitted to emergency management. The team roster only includes people deployed for that disaster for a specific mission.

Any state employee who is a certified disaster service volunteer of the American Red Cross may be granted leave for disaster response with the authorization of his or her supervisor. This leave is not to exceed fifteen working days in each calendar year. This specifically includes “all administrative, professional, academic, and other personnel of the University of Nebraska, the state colleges, and the State Department of Education.”²⁸ This potentially creates an avenue for employees to respond to disaster situations within organized response structures and obtain valuable experience and training.

Communications with Clergy

Communication with clergy is confidential if made privately and not intended for further disclosure except to other persons present in furtherance of the purpose of the communication. The person who communicated with clergy, his/her guardian or conservator, a personal representative if deceased, or the clergyman to whom the

²³ Nebraska Critical Incident Stress Management Act §§ 71-7101 to 71-7113; see also NAC Title 176 Chapter 1

²⁴ Nebraska Emergency Management Act § 81-829.48

²⁵ Nebraska Emergency Management Act § 81-829.56

²⁶ Nebraska Emergency Management Act § 81-829.41

²⁷ Nebraska Emergency Management Act § 81-829.52

²⁸ Nebraska Law § 81-1391

communication was made may claim privilege and refuse to disclose or prevent another from disclosing this confidential communication.²⁹

Governor's Emergency Authority

In the event of a disaster declaration by the Governor, the Governor may “suspend the provisions of any regulatory statute prescribing the procedures for conduct of state business or the orders, rules, or regulations of any state agency if strict compliance with the provisions of any statute, order, rule, or regulation would in any way prevent, hinder, or delay necessary action in coping with the disaster, emergency, or civil defense emergency.”³⁰ In order for this to be possible, requests for such an action by the Governor would have to be channeled through the Nebraska Emergency Management Agency, which is responsible for carrying out the provisions of the Emergency Management Act.

Liability Issues

The Nebraska All-Hazards Disaster Behavioral Health Plan is not a substitute for legal advice regarding liability. Efforts have been made to construct a system of deployment that maximizes protection from liability for volunteers. **There is no liability protection for volunteers who engage in illegal or unethical behavior while responding.** Volunteers are least liable when they:

1. Are part of a formal response activated by emergency management;
2. Operate within the scope of their licensure or responsibility area;
3. Are adequately trained and supervised when in the field.

The Appendix contains summaries of relevant regulations and statutes that may be of interest to the behavioral health disaster volunteer. Liability exposure is also related to supervision and use of best practices (refer to Section XII of this plan, particularly the parts on Supervision of Responders, and Best or Promising Practices).

Licensure is neither necessary nor sufficient to enable a person to be a disaster behavioral health responder. Specialized training in provision of psychological first aid can equip a person (who may be behavioral health professionals, alcohol and drug addiction specialists, faith leaders, health professionals, educators, other human service professionals, and trained community responders such as CISM peers or other community members) to function in the role of a disaster behavioral health responder.

Informed consent is a phrase that implies that a person knowingly gives consent to participate in an interaction with a behavioral health professional. Although psychological first aid is not treatment and informed consent is not required, it is important for behavioral health response volunteers to tell people they speak with that they are part of the behavioral health response. This gives individuals a chance to decline the interaction if desired.

²⁹ Nebraska Revised Statutes § 27-506

³⁰ Nebraska Emergency Management Act § 81-829.40

VI. Behavioral Health and NIMS

The National Incident Management System (NIMS) provides a consistent approach for government and private sector groups to work together to prevent, prepare for, respond to and recover from incidents regardless of the size or cause of the disaster. A best practice within NIMS is the Incident Command System (ICS). ICS is a way to organize and manage on-site response operations. Each entity involved in response should know, understand and be able to function within the structure of the Incident Command System. The framework of NIMS and ICS helps response operations scale up or down for an incident using a system to organize and manage the response that everyone is familiar with. Practically speaking, this means that every disaster behavioral health responder must have a working understanding of NIMS and ICS.³¹

In Nebraska, Disaster Behavioral Health is integrated within a larger Incident Command Structure on the site of a response operation. Typically, disaster behavioral health falls within the Operations Section of ICS. Behavioral health can also serve within the other ICS functions and may be expected to organize teams that address each of the five major incident command functions:

1. Command and Command Staff
 - a. Safety
 - b. Information
 - c. Liaison
2. Operations
3. Planning
4. Logistics
5. Finance



Command and Command Staff

Public Information

A behavioral health representative will often work with the designated Public Information Officer (PIO) to provide behavioral health messages and assist in monitoring hotline trends. This may involve being located at a Joint Information Center (JIC) to address the emotional and behavioral aspects of messages being developed and communicated. Behavioral Health within the public information function will:

- Assess the need for, and help to craft, special messages containing behavioral health content (i.e., coping with the stress of emergency evacuation, etc.).
- Coordinate information releases with information staff from other agencies and jurisdictions.
- Provide requested information about behavioral health issues related to the incident.
- If a hotline is set up, provide education to hotline personnel and assist in

³¹ Draft U.S. Department of Health and Human Services. All-Hazards Disaster Mental Health and Substance Abuse Preparedness Toolkit. Pre-publication version - Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009.

monitoring hotline trends related to behavioral health.

- Provide copies of all news releases, bulletins, and summaries pertaining to behavioral health to the PIO.

Liaison with Incident Command

Liaison functions are often accomplished through establishment of an Emergency Operations Center (EOC). If a behavioral health liaison is requested at the EOC, the behavioral health liaison will:

- Monitor EOC information to help structure the behavioral health response.
- Monitor the current behavioral health response and available resources to report back to the EOC.

Safety

Although this function is directly under the incident commander, it is also an inherent part of behavioral health operations. To assist with the safety function, behavioral health will:

- Identify psychological hazards associated with the incident
- Assess whether a location is safe for deploying behavioral health responders.
- Identify potential unsafe acts or practices in disaster behavioral health service delivery
- Identify corrective actions and ensure implementation
- Develop a plan for responder stress management (set up shifts if needed; enforce breaks/mealtimes/sleep times; provide education on worker stress and self-care)
- Coordinate post-deployment individual and/or group support or processing sessions
- Develop an exit plan for workers leaving operations (e.g., re-entry to normal life, recognition of response efforts)

Planning

One of the main tasks of the Planning Section is to create an Incident Action Plan (IAP). Behavioral health, as part of the Planning function, will:

- Assemble information for a behavioral health needs assessment
 - Determine current resource availability, situation status, and behavioral health objectives and strategy
- Activate additional personnel to assist with planning, if necessary
- Maintain a resource tracking system
- Gather information from operations and field staff
- Advise Planning Section staff of any significant changes in incident status related to the behavioral health impact of events

Operations

This is the primary behavioral health function within a response. This function will typically start on the local/Regional level. The Disaster Behavioral Health Coordinator, or designee, is responsible for the direct management of all incident-related operational activities. The person heading up Behavioral Health Operations (often positioned as a Branch Director, Division or Group Supervisor, or Unit Leader) will:

- Direct the behavioral health operations to complete the mission identified in the planning function
- Ensure that logistics support activities are sufficient to support the proposed operations
- Determine general organizational structure of the response
- Coordinate with the Planning function
- Develop a response schedule of activities and tactical assignments
- Review responder activities and modify them based on effectiveness/needs assessment
- Continually monitor current operations and their effectiveness
- Visit field locations to view activities and assess community needs
- Estimate immediate and long-range resource and logistical requirements
- If community needs are outside the scope of the mission assigned to behavioral health, request a revision of the mission or Incident Action Plan (IAP)
- Supervise and coordinate all behavioral health response activities
- If working in shifts, ensure all shift activities are passed on appropriately to incoming Behavioral Health Operations leaders

Logistics

Behavioral health functions within Logistics overlaps greatly with behavioral health functions in the Planning and Operations Sections. Much of the logistics support for behavioral health will be provided by emergency management, such as:

- Necessary communications equipment for field operations
- Transportation to/from field locations
- Meals or Lodging, if necessary

Within the Logistics function, behavioral health will:

- Receive requests for, and locate, behavioral health resources
- Identify staging areas to assemble behavioral health resources

Finance/Administration

The Finance/Administration function for behavioral health primarily involves tracking and reporting response activities. The person(s) serving in this role typically carry out the following duties:

- Obtain information on the required fiscal process and tracking forms
- Prepare cost estimates
- Ensure completeness of documentation needed to support claims for emergency funds
- Ensure all personnel time records reflect incident activity
- Ensure that all documents initiated by the incident are properly prepared and completed

VII. Plan Development and Maintenance

The DHHS Division of Behavioral Health is responsible for ongoing evaluation and updating of the Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan. The Plan will go through a formal review and re-write process every four years. Routine corrections and updates of the Plan will be informed by exercises and any disaster events that occur. Notification and contact lists will be updated semi-annually.

Changes to the plan should be communicated to stakeholders and other response agencies. Changes should be thoughtfully considered and made in a manner that maintains or enhances compatibility with other state plans.

VIII. Mass Care (ESF-6)

The Division of Behavioral Health, as part of Nebraska DHHS, coordinates with NEMA, the American Red Cross, and other ESF-6 partners to provide for the immediate and short term behavioral health and spiritual care needs of disaster victims, families of victims and responders. Responsibilities are the same as those described in the Nebraska State Emergency Operations Plan ESF-8, Health and Medical.

IX. Health and Medical (ESF-8)

ESF-8 details the Nebraska DHHS Behavioral Health response and recovery procedures. The responsibilities of the Division of Behavioral Health are to:

- Assist local government and Regional Behavioral Health Authorities in the assessment of behavioral health needs
- Identify emerging behavioral health needs of the affected area

- Determine the extent of the local or regional behavioral health response that has been or is currently active
- Procure and coordinate resources that may be required to meet the behavioral health needs of the affected area
- Coordinate with behavioral health disaster resources at the local and regional levels
- Coordinate services with other responding agencies to provide behavioral health services to emergency responders
- Coordinate with the State Joint Information Center to provide behavioral health information to those affected
- Monitor and coordinate the deployment of behavioral health resources
- Complete and submit the FEMA Crisis Counseling Program grant.

X. Agriculture (ESF-11)

Under ESF-11, the Nebraska DHHS Division of Behavioral Health is responsible for providing mental health support to survivors, emergency responders, those that suffer significant property loss and the public in general to prevent or minimize stress, grief, and depression that can occur following natural or manmade disasters. Procedures are the same as under ESF-8, with the added requirement of coordinating with the Nebraska Department of Agriculture.

XI. Resource Management

Disaster Behavioral Health Resources in Nebraska

There are a number of organizations and programs whose role in disaster response includes addressing behavioral health needs. In addition to the organizations listed below which focus on disaster response, behavioral health disaster response and recovery will require working in concert with multiple groups, such as local community social services and behavioral health providers, to serve the behavioral health needs of a community affected by a disaster.

Formal State Resources

- **Nebraska Behavioral Health Emergency Response Team (BHERT):** The BHERT is a mechanism for organizing and deploying state disaster behavioral health resources. The primary value of the team to local areas is rapid deployment of behavioral health personnel experienced in disaster-related community needs assessment, coordination of resources, and training. NBHERT is also a resource for state-run facilities and emergency response operations, and it is expected that NBHERT will be available as a resource of the Governor in the event behavioral health expertise is requested by another state.

- **Nebraska Risk Communication Cadre:** This pool of behavioral health and public information professionals with competency³² in risk communication, risk assessment, and public information includes behavioral health professionals, subject matter experts, and State Public Information Officials (PIOs). These professionals may serve as a consultant³³ to local areas or joint information centers. The group meets regularly to craft messages with behavioral health content for use in all phases of disaster.
- **Nebraska CISM Program:** This is a statewide program authorized under Nebraska Statute.³⁴ Critical Incident Stress Management (CISM) Teams are organized by State Patrol Troop area. The system uses volunteer mental health professionals and peers trained to support the psychological health and functioning of first responders and other emergency personnel: Law Enforcement, Firefighters, Emergency Medical Services, Corrections, Hospital personnel, Emergency Management Personnel, and Dispatchers. The teams are coordinated by the Nebraska Department of Health and Human Services, Division of Public Health, Emergency Medical Services Program.
- **ESAR-VHP (Emergency System for Advance Registration of Volunteer Health Professionals):** The Nebraska Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program is an electronic database of healthcare workers (including behavioral health) willing to volunteer to work during disasters or large scale emergencies. It is more commonly known as the Nebraska Medical and Health Volunteer Registry. The on-line registration system includes verifiable, up-to-date information regarding the potential volunteer's identity, license, professional credentials and privileges in hospitals or other medical facilities. The State of Nebraska owns, maintains, monitors and secures the database. The U.S. Department of Health and Human Services requires all States to develop a system for the advance registration of health professionals with the ultimate goal of linking States to create a national database of potential health care volunteers.
- **Public Behavioral Health System:** The publicly funded mental health and substance abuse services in Nebraska are organized by defined geographic service regions. Each Region has an identified network of service providers who receive public funds to provide mental health, substance abuse, and addiction services in the area.

Other Resources

- **Medical Reserve Corps (MRCs):** The Nebraska Medical Reserve Corps is a community-based program focused on improving the health, safety and resiliency of local communities. MRC units organize volunteer health and medical professionals (including behavioral health) and other support personnel who volunteer to promote healthy living throughout the year and to prepare

³² See the Appendix for qualities and competencies required of persons in the Risk Consultant role.

³³ The role of consultant is to offer professional advice within the scope of licensure and competence of the practitioner.

³⁴ Nebraska Critical Incident Stress Management Act §§ 71-7101 to 71-7113

for and respond to emergencies. MRC units in the State of Nebraska are geographically based to serve multi-county areas. MRC's have minimum training requirements to ensure volunteers are prepared to respond in emergency situations. They may be a source of behavioral health response volunteers, when additional volunteers are needed.

- **American Red Cross:** Red Cross disaster mental health services are readily available in the most populous areas of the state and somewhat available in other parts of Nebraska. The State of Nebraska currently has a policy that allows state employees two weeks of paid time to respond to disaster in Nebraska as part of the Red Cross response.³⁵ The Red Cross uses only licensed mental health professionals to provide mental health services for survivors of a disaster and for Red Cross workers.³⁶ The Red Cross also provides formal Disaster Spiritual Care (DSC) training for volunteers. Faith leaders are often part of the behavioral health response, but they formally occupy the role of providing spiritual care when operating within Red Cross structures.
- **NEVOAD:** Nebraska Voluntary Organizations Active in Disaster are involved in a variety of disaster response activities in the state.
- **Employee Assistance Programs (EAPs)**
- **Faith leaders / Disaster Spiritual Care Volunteers:** Nebraska recognizes that faith leaders and disaster spiritual care volunteers have a special role in disaster response. They are uniquely positioned to provide spiritual care for many individuals in an affected population.
- **Community volunteers**
- **School crisis teams**
- **Private mental health and substance abuse practitioners**

Organization of a Behavioral Health Response to Disaster

Organization of the behavioral health work force for disaster response occurs at the local and regional level. This work force is mostly volunteers, and consists of behavioral health professionals, alcohol and drug addiction specialists, faith leaders, health professionals, educators, other human service professionals, and community responders like CISM peers or community members trained to respond to disaster.³⁷

³⁵ Nebraska Emergency Management Act § 81-1391

³⁶ The original Congressional Charter for the American Red Cross was in 1900. A new charter was given in 1905 with several amendments since. For more history of the American Red Cross see <http://www.redcross.org/museum/history.html>

³⁷ Community members trained to augment the behavioral health response to disaster could include farmers, ranchers, minority group members, and other natural helpers. Training refers to education and practice of psychological first aid.

Regional Behavioral Health Authorities

Regional Behavioral Health Authorities represent multi-county geographic areas with an existing organizational structure for public behavioral health resources. The Regions also have responsibility related to organization and coordination of emergency behavioral health services in the State.³⁸ Regions may choose to extend their emergency capacity by taking on some or all of the responsibilities for coordinating capacity development for the disaster behavioral health work force or may choose to relinquish this responsibility by designating a consenting community partner for this work. The Regional Behavioral Health Program Administrator will include information about how their Region intends to coordinate capacity development in the Region's Behavioral Health All Hazards Disaster Response and Recovery Plan and provide the plan to the Division of Behavioral Health.

The Regions may provide leadership or designate a consenting community partner as the area leader as Nebraska moves toward the development of a listing or database of pre-identified disaster behavioral health responders that can potentially respond to a local, regional, or statewide disaster.³⁹

Pre-identification is important for several reasons:

- It provides a more accurate picture of Nebraska's behavioral health disaster response capabilities
- It facilitates quick and strategic deployment of human resources
- Pre-identifying can assist in getting appropriate help to affected areas that may be restricted.

For those who are pre-identified, information is readily available to confirm their identity and their qualifications so that an access ID can be issued to them quickly. Not being listed in the database does not prevent a qualified disaster behavioral health responder from assisting with the response, but it does take longer to verify their qualifications.

Credentialing

Licensed/certified behavioral health professionals must always bring their professional license with them when they respond to a disaster.

Regional Behavioral Health Authorities and local emergency management agencies are urged to pre-identify volunteer community responders when possible. The Regions and local emergency management should coordinate any pre-credentialing and issue ID's suitable for local response needs to those who participate in trainings and are listed in the Regional responder databases.

Those who respond with the American Red Cross (ARC) or a Nebraska CISM team are already credentialed through their respective programs, and their ARC and/or CISM ID's will be accepted as credentials for participating in a Regional, or state behavioral health disaster response.

³⁸ Nebraska Administrative Code Title 204 Chapter 3-008

³⁹ Credentialing disaster mental health volunteers includes verification of current licensure, adequate training, and any screening required by local areas or law enforcement to gain access to restricted sites.

Supervision of Responders During Disaster Response

Nebraska recognizes that the initial phases of disaster response are intense and often chaotic, requiring supervisors to be skilled and experienced in disaster behavioral health work. For this reason, supervision of field work should fall to licensed mental health professionals, preferably with disaster response training and experience.

1. Adequate clinical supervision of behavioral health disaster responders protects both service recipients and responders.
2. Licensed mental health professionals with experience in assuming clinical supervision roles should use the following guidelines to provide “adequate supervision” to behavioral health disaster responders:
 - Supervisors must be able to adequately oversee and control their subordinates, as well as communicate with and manage all resources under their supervision. In ICS, the span of control of any individual should range from 3 to 7 subordinates or teams. The type of incident, safety factors, and distances between personnel and resources all influence span-of-control considerations
 - Be accessible to responders in the field – this includes availability by phone or radio for immediate consultation, and availability on site for intervention or referral
 - Insist that behavioral health responders receive orientation prior to service and opportunities for defusing/debriefing following service
 - Insist that behavioral health responders be deployed in teams – never solo
 - Take time to know the strengths and limitations of the responders assigned to you for supervision
 - Consider pairing community responders with licensed behavioral health, credentialed clergy, active CISM peer, or ARC Disaster Mental Health responder if possible – use a “buddy system”
 - Insist that behavioral health responders identify themselves to survivors and those they are serving to allow the potential recipient of service to decline if desired
 - Licensed behavioral health responders should identify themselves according to their licensed profession
 - Community responders should identify themselves as “psychological support” volunteers
 - Insist that behavioral health responders who are licensed mental health professionals conform to provision of informed consent when engaging in formal interventions such as debriefing – reviewing the potential risks and benefits prior to beginning the intervention

- Work with administrative personnel to create reasonable working hours and conditions for those you supervise
- 3. Region Behavioral Health Authorities without immediate access to licensed mental health professionals experienced in disaster response should request the addition of such a responder as soon as possible, from local network providers, other Regional Authorities, or the Division of Behavioral Health. Community responders assuming a lead role in behavioral health responses in the interim should be cognizant of the guidelines listed above when actively deploying or supervising behavioral health responders immediately following a disaster.
- 4. The behavioral health response is part of an overall coordinated health response. Clinical supervisors should keep administrative personnel apprised of activities in the field through incident command structures. The clinical supervisors may also be in the field and can forward information to administrators about conditions, responses, and concerns that may contribute to the coordination of an overall response that more effectively meets the needs of those affected.

Best or Promising Practices

Mental Health and Disaster

Information on best or promising practices is emerging from ongoing research. The following recommendations are based on what is currently known.

- Any psychological defusings/debriefings requested or undertaken under the State Behavioral Health All-Hazards Disaster Response and Recovery Plan will be voluntary on the part of participants
 - The Nebraska Critical Incident Stress Management (CISM) Program has its own guidelines and operating procedures to serve the mental health needs of first responders, and will follow those guidelines
- The number of responders activated should be enough to have a **consistent** presence at sites of intervention
 - Behavioral health responders should spend adequate time at a site to ensure behavioral health needs are met

Substance Use/Abuse and Disaster

Current research indicates that although alcohol and other substance use increases after a disaster, it increases only for those who had pre-existing substance use/abuse issues.⁴⁰ In general, disasters do not appear to trigger new cases of substance use/abuse in survivors and first responder populations.

Nebraska's Opioid Treatment Programs (OTP) are subject to federal regulations that

⁴⁰ North, C. (2004, July). Data-based foundations for disaster mental health intervention and policy. Presented at the Second Annual Nebraska Disaster Behavioral Health Conference, Omaha, NE.

make them unique.⁴¹ Regions with these Programs in their areas should communicate with them in advance to ensure viable continuity of operations plans are in place that ensure back up service for current clientele. A large scale disaster may also increase the role of these Programs by creating potential new consumers who may require rapid identification and enrollment. Inclusion of Opioid Treatment Programs in disaster planning at the Regional level is encouraged.

XII. Special Situations / Response Plans

The following special situations have either additional task requirements, or special organizational details to be considered when deploying disaster behavioral health resources. The State Disaster Behavioral Health Coordinator is responsible for coordinating these details.

State Declaration of Disaster

Work closely with the Nebraska Emergency Management Agency (NEMA) to determine if State resources are available to fund deployment of personnel. A State declared disaster may also place some state employees in a position to respond either as part of the disaster behavioral health response (if qualified) or as part of an American Red Cross response.⁴²



Presidential Declaration of Disaster

If a presidential disaster declaration makes individuals eligible for assistance, a Federal Emergency Management Agency (FEMA) Crisis Counseling Training and Assistance Program (CCP) grant must be applied for within 14 days of the declaration.⁴³ The Immediate Services Program (ISP) Application covers the first 60 days of services. A Regular Services Program (RSP) Application is due within 60 days of the presidential declaration, and provides funds for an additional 9 months of services. See the Appendix for further information.

⁴¹ Federal Regulation 42 CFR Part 8

⁴² Nebraska Emergency Management Act § 81-1391

⁴³ Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 1974, authorizes FEMA to fund mental health assistance and training activities in areas which have been presidentially declared a disaster. Only a State or a Federally-recognized Indian Tribe may apply for a crisis counseling grant.

Activation of State Emergency Operations Center (EOC)

If the State Emergency Operations Center (EOC) is activated, the State Disaster Behavioral Health Coordinator takes the following actions:

- Work with ESF8 Coordinator to establish Behavioral Health objectives for Behavioral Health personnel.
- Work with the Public Information Officer (PIO) to activate a Risk Communication Consultant if needed and release messages with behavioral health content.
- Work with Regional Behavioral Health Authorities to identify behavioral health personnel to consult in any call centers that are activated by the State. The Nebraska Rural Response Hotline has historically served as the hotline for crisis counseling response and referral.⁴⁴
- Communicate regularly with local and/or Regional behavioral health contacts at the disaster site to obtain status reports and provide updates on state activities related to disaster response.
- Ensure that State response teams have access to qualified behavioral health service during and following their assignments.
- State Disaster Behavioral Health Coordinators or staff from the Division of Behavioral Health may be asked to travel to the disaster site to assist local and Regional resources in assessing behavioral health needs or coordinating the behavioral health response. This may be done as part of the staff person's regular job, or as a volunteer activated by the Nebraska Emergency Management Agency.
- A daily log of activities should be kept by Coordinators and passed from shift to shift.

Requesting Assistance from Other States

If the type, scope, or scale of a disaster is such that behavioral health resources from other states are needed, the Interstate Emergency Management Assistance Compact (EMAC) may be activated. To request behavioral health resources from other states, the State Disaster Behavioral Health Coordinator sends a request to the ESF #8 Coordinator. The ESF #8 Coordinator then contacts the incident commander, who will follow the standard operating procedures for requesting assistance from other states.

Large Scale Behavioral Health Emergencies

Typically, the behavioral health response is part of a larger response in which emergency management, public health, or the Department of Agriculture is the lead agency. However, there are some situations, declared by the Governor, in which the Regional Behavioral Health Authority or the Nebraska DHHS Division of Behavioral Health will be designated the lead agency. This may be particularly true in the recovery period after events that involve multiple casualties but little to no property damage. The Region or Division will take a more active role in decision-making in these situations. Many other response activities and responsibilities will not change.

⁴⁴ See the Appendix for Memorandum of Understanding with the Rural Response Hotline.

State Operated Facility is Involved in the Disaster

Nebraska Department of Health and Human Services oversees numerous facilities, including four Veterans' Homes, three psychiatric regional centers, two youth rehabilitation and treatment centers, and one habilitation campus for developmental disabilities.

- Refer to the disaster plan of the facility for operational details.
- Work with the facility management to determine if additional resources are needed by customers, staff, and their families to meet the behavioral health needs that result from the disaster.
- Involve local and Regional resources in a behavioral health response to a disaster that involves a state operated facility when possible.
- Contact other state operated facilities to determine if qualified personnel are available to serve as part of the behavioral health response to the affected facility.

Air Transportation Incidents

- According to Federal law and their agreement with the National Transportation and Safety Board (NTSB), the American Red Cross is responsible for responding to all of the behavioral health needs of survivors of the incident, and families of survivors and victims.^{45, 46}
- The Regional Behavioral Health Authority responsible for the geographic area in which the air transportation incident occurred should be ready to assist with any requests from the Red Cross or the NTSB.
- The Regional Behavioral Health Authority is responsible for serving the behavioral health needs of the community in which the incident occurred.

Terrorism/Bioterrorism

- Incidents of terrorism, particularly biological or chemical terrorism, create fear. The role of behavioral health becomes acutely important in these instances. The State Disaster Coordinator will advocate for inclusion of a risk communication consultant in planning and discussions with public health, the public information officer, government officials, and law enforcement. The level of security will be higher than for a natural disaster as a criminal investigation is potentially part of the incident response.
- Instances of quarantine or recommendations to shelter in place should trigger the opening of a hotline that will require continuous staffing by behavioral health professionals.

⁴⁵ Aviation Disaster Family Assistance Act of 1996, Public Law 104-264, Title VII

⁴⁶ Statement of Understanding between American Red Cross and National Transportation Safety Board , September 28, 1998, as cited in: National Transportation Safety Board (2000). Federal Family Assistance Plan for Aviation Disaster.

Agricultural Terrorism / Disease Outbreak

- Agricultural terrorism or disease outbreak that results in depopulation of animals or quarantine of farms/ranches should trigger strategic deployment of professionals familiar with rural issues and community responders able to relate to rural populations. Work with the Regional Disaster Behavioral Health Coordinators to insure that these responders in the field communicate their observations and activities to the State Behavioral Health Disaster Coordinator.
- Communicate with the State Veterinarian within the Department of Agriculture to determine need for local or on site consultation between members of the Livestock Emergency Disease Response System (LEDERS) group and behavioral health.

Research Requests

- The Division of Behavioral Health will work with the University of Nebraska to designate an appropriate department of the University to coordinate behavioral health research following a disaster, as recommended by the American Psychological Association (APA).⁴⁷ All research following a disaster must be approved through the process designated by the University. Information on which department to contact and the process to follow when submitting a research request is contained in the Appendix.

⁴⁷ American Psychological Association (July 1997). Final Report: Task Force on the Mental Health Response to the Oklahoma City Bombing. Washington, D.C.: Author.

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